INTRODUCTION

The *AHCCCS Fee-for-Service Remittance Advice* provides information about how claims were paid, pended, or voided and why claims were denied. You may receive your Remittance Advice electronically or on paper. Both the electronic and paper remittance advice are generated weekly.

ELECTRONIC REMITTANCE ADVICE

You may download a HIPAA-compliant 835 electronic remittance advice from a secure AHCCCS Internet Web site and store the remittance in either electronic or hardcopy format.

The electronic remittance advice (ERA) is available on the AHCCCS Online Web site application. To create an account and begin using AHCCCS Online, go to the AHCCCS Home Page at www.ahcccs.state.az.us. Click on Links for Plans & Providers link to go to the Quick Links for Health Plans and Providers page. A link on the page allows providers to create a free account.

After accessing the AHCCCS Online Web site, you must download a copy of a trading partner agreement (TPA) and the Electronic Remittance Advice Manual. The manual includes all forms that must be submitted to AHCCCS in order for you to receive your remittance electronically.

The TPA must be submitted to the AHCCCS Electronic Claims Submission (ECS) Unit. You also must complete testing with AHCCCS prior to receiving a production 835. The ECS Unit will track the testing and provide technical assistance. Once you have passed testing requirements, the ECS unit will notify you that you may receive the 835 remittance advice in production.

If you have no available remittance files, the Electronic Remits page will be displayed with the message “No files available.”

If you have remittance files available for download, they will be listed on the Electronic Remits page. You will receive both an 835 remittance file of paid and denied claims and a supplemental file containing pended claims and additional data related to the paid and denied claims, for each applicable remittance date. Once the remittance file(s) have been saved, they can be accessed and displayed in any text editor (Notepad, Wordpad, Winword, etc.)

Remittance files are retained by AHCCCS Online for two weeks. After two weeks, they will no longer be available via AHCCCS Online. To obtain a paper copy of your remittance advice, you must contact the AHCCCS Finance Department. There is a charge of $2.00 per page for the paper copy.

Questions about the electronic remittance should be directed to the ECS Unit at (603) 417-4706 or (603) 417-4892.

PAPER REMITTANCE ADVICE

The paper Remittance Advice is generated weekly and mailed to the billing provider. If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each.

NOTE: ACH payments (electronic reimbursement) are sent directly to your bank. Paper copies of the Remittance Advice are mailed to your pay-to address. If your pay-to address is a lockbox at the bank, you should contact the Provider Registration Unit to change the pay-to address to the location where your payment posting occurs. This will prevent delays in receiving the remits from the lockbox. If duplicate remits are needed, there is a charge of $2.00 per page to reproduce.

The *Non-Facility Remittance Advice* is mailed to providers who bill on the CMS 1500 and the ADA 2002 claim forms. The *Facility Remittance Advice* reports information related to services billed on the UB-92 claim form. You may receive an Acute Remittance, a Long Term Care Remittance, a KidsCare Remittance or all three within a Remittance Advice package. The terms Acute, Long Term Care, and KidsCare designate the eligibility category of the recipients and do not refer to the provider.

A separate remittance is generated for claims for recipients who receive behavioral health services through a regional behavioral health authority (RBHA) or a tribal behavioral health authority (TRBHA). This remittance is identical in format to the remittance generated for other providers.

Each Remittance Advice is divided into seven sections:

- ☑ Paid claims
- ☑ Adjusted claims
- ☑ Denied claims
- ☑ Voided claims
- ☑ Claims in process (pended)
  - ✓ This section includes claims reported on a previous Remittance and still in process.
- ☑ Processing Notes
  - ✓ The page provides a listing of denial reason codes and pricing explanation codes.
  - ✓ Each is listed only once even if it applies to multiple claims.
- ☑ Grievance Process
  - ✓ This page informs providers of their grievance rights. (See Chapter 19, Claim Disputes)

NOTE: The remainder of this chapter applies to the paper Remittance Advice.

ADDRESS PAGE AND FINANCIAL SUMMARY

The ***Address Page*** of the Remittance Advice (Exhibit 18-1) displays the billing provider's name and pay-to mailing address.

The ***Financial Summary*** page (Exhibit 18-2) reports check and invoice data. If all claims are in process or denied, the page will indicate "No Active Invoices."

Information reported on the Financial Summary page includes:

- ☑ BILLING PROVIDER ID number plus locator codes and name.
- ☑ SERVICE PROVIDER ID number plus locator codes and name.
- ☑ TAX ID of the billing provider.
- ☑ PAYMENT DATE is the check date.
- ☑ PAY FOR CATEGORY.
  - ✓ Acute, Long Term Care, and KidsCare totals (as applicable) are printed on separate lines.
- ☑ CHECK NUMBER.
  - ✓ Providers receive separate checks for each Pay For Category.
- ☑ INVOICE DATE.
- ☑ INVOICE NUMBER links payments to the services that generated the payment.
- ☑ TYPE column will indicate "CR" if the provider has a credit.
- ☑ GROSS AMOUNT is the total remitted for each Pay For Category.
  - ✓ A negative total means no payment on this remittance.
  - ✓ Gross Amount and Net Amount are usually equal unless there is a credit memo (negative invoices or recouped claims).
- ☑ DISCOUNT is never used for AHCCCS fee-for-service providers.
- ☑ NET AMOUNT is the check amount for each Pay for Category.
  - ✓ If there are outstanding credit memos, this will show zero until enough approved claims are processed to offset the credit.

NON-FACILITY PAID CLAIMS

The ***Paid Claims*** section for non-facility claims (Exhibit 18-3) displays the following data:

- ☑ INVOICE DATE is the date AHCCCS processed the claims for payment.
- ☑ BILLING PROVIDER ID number plus locator codes and name.
- ☑ SERVICE PROVIDER ID number plus locator codes and name.
- ☑ INVOICE NUMBER matches the number on the Financial Summary.
- ☑ CHECK NUMBER matches the number on the Financial Summary.
- ☑ PAYMENT DATE is the date of the reimbursement check.
- ☑ TAX ID of the billing provider.
- ☑ FORM TYPE will be CMS 1500 or ADA 2002 claim form.
- ☑ AHCCCS ID of the recipient.
- ☑ RECIPIENT is the ID number submitted on the claim.
- ☑ NAME of the recipient as recorded in the AHCCCS system.
- ☑ PATIENT ACCOUNT NUMBER is the number you entered on the claim in the patient account number field.
- ☑ PRICE EXPL is the pricing explanation code.
  - ✓ Definitions are printed on the Processing Notes page.
  - ✓ An asterisk (*) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).
- ☑ CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- ☑ SCORE DATE is the most recent date the claim was adjudicated (attained "Paid" status).
- ☑ SERVICE CD/MODIFIER is the CPT/HCPCS procedure code submitted on the claim.
  - ✓ Any procedure modifier would be printed below the procedure code.
- ☑ DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
  - ✓ If dates are the same, only one date is displayed.
- ☑ BILLED AMOUNT submitted on the claim.
- ☑ BILLED UNITS reflects the number of units submitted on the claim.

NON-FACILITY PAID CLAIMS (CONT.)

The ***Paid Claims*** section for non-facility claims (Cont.):

- ☑ ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ☑ ALLOWED AMOUNT may be based on the AHCCCS capped fee, Medicare Coinsurance and Deductible, etc.
- ☑ NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.

The following summary is listed at the end of each Non-facility Paid Claims section:

- ☑ NUMBER OF CLAIMS is the total number of claims in the Paid Claims section.
- ☑ TOTAL BILLED AMOUNT for all claims in the Paid Claims section.
- ☑ TOTAL REMIT AMOUNT for all claims in the Paid Claims section.

NON-FACILITY DENIED CLAIMS

The ***Denied Claims*** section for non-facility claims (Exhibit 18-4) displays much of the same data as the Paid Claims section.

Because no reimbursement is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

The Denied Claim section adds a REASON CDS field that lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

You should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when you resubmit the denied claim or if you contact the AHCCCS Administration with questions about the claim.

The following summary is listed at the end of each Non-facility Denied Claims section:

- ☑ NUMBER OF CLAIMS in the Denied Claims section.
- ☑ TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

NON-FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for non-facility claims (Exhibit 18-5) displays much of the same data as the Paid Claims section.

The Adjusted Claims section adds a PREVIOUSLY PAID field that displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of each Non-facility Adjusted Claims section:

☑ NUMBER OF CLAIMS is the total number of claims in the Adjusted Claims section.

☑ TOTAL BILLED AMOUNT for all claims in the Adjusted Claims section.

☑ TOTAL REMIT AMOUNT for all claims in the Adjusted Claims section.

NON-FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims (Exhibit 18-6) displays much of the same data as the Paid Claims section:

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than the amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are "backed out" and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Non-facility Voided Claims section:

☑ NUMBER OF CLAIMS in the Voided Claims section.

☑ TOTAL BILLED AMOUNT for all claims in the Voided Claims section.

☑ TOTAL RECOUPED AMOUNT for all claims in the Voided Claims section.

NON-FACILITY CLAIMS IN PROCESS

The *Claims in Process* section (Exhibit 18-7) of the Remittance Advice for non-facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously.

The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of each Non-facility Claims in Process section:

☑ NUMBER OF CLAIMS is the total number of claims in process.

☑ TOTAL BILLED AMOUNT for all claims in process.

NON-FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* (Exhibit 18-8) section displays the following data:

☑ BILLING PROVIDER ID number plus locator codes and name.

☑ SERVICE PROVIDER ID number plus locator codes and name.

☑ NOTE is an alphabetical listing of processing codes (denial or void reason codes, pricing method codes, etc.).

- ✓ Each code is listed only once even if applicable to multiple claims.

☑ TYPE lists the type of code.

M = Pricing Method

P = Pricing Type

R = Reason Code

T = Tier

X = Modifier

☑ DESCRIPTION is the description of a processing note code.

Example:

H199.4 R CLAIM RECEIVED PAST 6 MONTH LIMIT

FACILITY PAID CLAIMS

The *Paid Claims* section for inpatient and outpatient facility claims (Exhibit 18-9 and Exhibit 18-10) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- ☑ The FORM TYPE will be Inpatient (includes inpatient hospital and nursing home) or Outpatient (for KidsCare recipients).
- ☑ PRICE EXPL is the pricing explanation code.
  - ✓ Definitions are printed on the Processing Notes page (e.g., PDM = per diem, MCD = Medicare Deductible).
- ☑ TIER DATA displays the number of accommodation days billed, the AHCCCS allowed days, and reason codes for any disallowed and cutback days.
- ☑ BILLED UNITS reflects accommodation days for inpatient claims.
  - ✓ This field is not populated for outpatient UB-92 claims.
- ☑ ALLOWED UNITS reflects accommodation days for inpatient claims.
  - ✓ This field is not populated for outpatient UB-92 claims.

The following summary is at the end of each Paid Claims section:

- ☑ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- ☑ TOTAL BILLED AMOUNT for all claims in the section.
- ☑ TOTAL REMIT AMOUNT for all claims in the section.

FACILITY DENIED CLAIMS

The *Denied Claims* section for facility claims (Exhibit 18-11) displays much of the same data as the Paid Claims section.

Because no reimbursement is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

The REASON CDS field lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Denied Claims section:

☑ NUMBER OF CLAIMS in the Denied Claims section.

☑ TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for facility claims (Exhibit 18-12) displays much of the same data as the Paid Claims section:

The PREVIOUSLY PAID field displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of the Adjusted Claims section:

☑ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.

☑ TOTAL BILLED AMOUNT for all claims in the section.

☑ TOTAL REMIT AMOUNT for all claims in the section.

FACILITY VOIDED CLAIMS

The *Voided Claims* section for facility claims (Exhibit 18-13) displays much of the same data as the Paid Claims section:

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are "backed out" and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Voided Claims section:

☑ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.

☑ TOTAL BILLED AMOUNT for all claims in the section.

☑ TOTAL RECOUPED AMOUNT for all claims in the section.

FACILITY CLAIMS IN PROCESS

The *Claims in Process* section (Exhibit 18-14) of the Remittance Advice for facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously:

The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of the Claims in Process section:

☑ NUMBER OF CLAIMS, both inpatient and outpatient, in process.

☑ TOTAL BILLED AMOUNT for all claims in process.

FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* section for both Acute and Long Term Care claims displays the same type of information as does the Processing Notes section for non-facility claims (Exhibit 18-8).

WORKING THE REMITTANCE ADVICE

Here are some suggestions for working the AHCCCS Remittance Advice to reconcile claims billed to the AHCCCS Administration and the status of those claims:

1. Review the Paid Claims section of the Remittance Advice to determine which claims have been paid and if those claims are paid correctly. Any errors, such as claims that have not paid the correct number of units, should be marked for adjustment, noting the associated CRNs. (See Chapter 4, General Billing Rules, for information on adjusting a paid claim.)

2. Review the Adjusted Claims section of the Remittance Advice. This section will report any claims that you submitted as adjustments because they were not paid correctly. If problems still exist with a claim, you may submit it again as another adjustment. This section also will report any claims that were adjusted by AHCCCS as a result of an audit or review.

3. Review the Voided Claims section of the Remittance Advice. This section will report any claims that you submitted as void transactions. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that AHCCCS can recoup its payment. This section also will report any claims that were voided by AHCCCS as a result of an audit or medical review recoupment. If you believe that a claim was voided in error, contact the AHCCCS Claims Customer Service Unit.

4. Review the Denied Claims section of the Remittance Advice. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 4, General Billing Rules, for information on resubmitting a denied claim.)

Contact the AHCCCS Claims Customer Service Unit if you have questions about the Remittance Advice or about resubmitting, adjusting, or voiding a claim:

(603) 417-7670 (Phoenix Area)

(800) 794-6862 (In state)

(800) 523-0331 (Out of state)